MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
March 19, 2015 - 9:30 am to 1:00 pm
United Way Conference Center, Room F
1111 9th Street, Des Moines, Iowa
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Thomas Bouska
Neil Broderick
Thomas Broeker
Marsha Edgington
Lynn Grobe
Kathryn Johnson
Betty King
Sharon Lambert
Geoffrey Lauer
Brett McLain (by phone)
Rebecca Peterson
Michael Polich (by phone)
Deb Schildroth
Patrick Schmitz
Marilyn Seemann
Suzanne Watson

MHDS COMMISSION MEMBERS ABSENT:

Senator Mark Costello
Richard Crouch
Representative Dave Heaton
Representative Lisa Heddens
Geoffrey Lauer
Senator Liz Mathis

OTHER ATTENDEES:

Theresa Armstrong	MHDS, Bureau Chief Community Services & Planning
Bob Bacon	U of Iowa Center for Disabilities and Development
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI Greater DM
Lisa D'Aunno	The University of Iowa NRC on Family-Centered Practice
Kristi Dierking	Mid-Iowa Behavioral Health
Jody Eaton	Central Iowa Community Services
Deb Eckerman Slack	ISAC Case Management and MHD Services
Marissa Eyanson	Easter Seals Iowa
Connie Fanselow	MHDS, Community Services & Planning
Jim Friberg	Department of Inspections and Appeals
Diane Funk	The University of Iowa Center for Child Health Improvement and Innovation
Deborah Johnson	Iowa Medicaid Enterprise, Long Term Care Bureau Chief
Liz Matney	Iowa Medicaid Enterprise, Managed Care Director
Vickie Miene	The University of Iowa Center for Child Health Improvement and Innovation
Marcy Murphy	Southeast Iowa Case Management
Caitlin Owens	U of Iowa Center for Disabilities and Development
Peter Schumacher	MHDS, Community Services & Planning/CDD
Rick Shults	MHDS Division Administrator
Doug Wilson	Integrated Telehealth Partners

Welcome and Call to Order
Patrick Schmitz called the meeting to order at 9:30 am and led introductions. Quorum was established with fifteen members present. No conflicts of interest were identified for this meeting.

Approval of Minutes
Neil Broderick made a motion to approve the minutes of the February 19 meeting as presented. Lynn Grobe seconded the motion. The motion passed unanimously.

New Commission Appointments
Patrick Schmitz announced the appointments to the Commission made by the governor and approved by the senate. Present terms end April 30 and new members will begin May 1. The appointees are as follows:

Jennifer Sheehan is the Wright County Coordinator of Disability Services from Clarion and will be replacing Deb Schildroth.

Jody Eaton is the Jasper County Community Services Director from Newton and will be replacing Suzanne Watson.

John Parmeter is a member of the Orchard Place Board of Directors from Des Moines and will be replacing Neil Broderick.

Rebecca J. Schmitz is the Jefferson County Supervisor from Fairfield and will be replacing Jill Davisson.

Patrick Schmitz has been re-appointed to a second term.

Iowa Peer & Family Peer Support Training Program presented by Vickie Miene, Diane Funk, and Lisa D'Aunno, The University of Iowa Center for Child Health Improvement and Innovation

Vickie Miene is the Executive Director for the Center for Child Health Improvement and Innovation. She has a background in clinical psychology and is a licensed mental health therapist. She is a former foster parent and has adopted four children with special mental health needs.

Diane Funk is the program coordinator for the Peer Support Specialist (PSS) and Family Peer Support Specialist (FPSS) project. She has more than twenty years of experience as a peer advocate in the domestic abuse and sexual assault field, and worked with the State of Iowa in the 1980s to write the certifications for centers and sexual assault advocates.

Lisa D'Aunno is the Training Director for the National Resource Center for Family-Centered Practice at The University of Iowa School of Social Work. She is has a law degree and has primarily represented children and parents in juvenile court and child-abuse and neglect cases. Before this position, she was the director for the National Resource Center for In-Home Services at The University of Iowa.

The Center for Child Health Improvement and Innovation (CCHII) was established to conduct health outcomes and systems research in pediatric and community practice. CCHII is taking the lead in this project in a partnership with the National Resource Center for Family-Centered Practice, ASK (Access for Special Kids) Resource Center, NAMI (National Alliance on Mental Illness) Iowa, and Child Health Specialty Clinics. The Iowa Peer and Family Peer Support Training Program is a project to provide comprehensive training for Iowa's peer support and family peer support workforce. CCHII was awarded the contract for this initiative through a DHS request for proposals (RFP) process.

The RFP divides the project into three work plans. Work Plan One is focused on recruiting and training and has been submitted to DHS. CCHII intends to recruit, train, and retain additional PSS and FPSS for the workforce in Iowa. To this end they are reviewing existing curricula for similar programs in Iowa and engaging stakeholders in a series of listening and feedback sessions across the state. Advisory committees will be doing peer review to maintain quality and regulate the curriculum and certification requirements. A draft of the curriculum is due by July 16. CCHII intends use a co-trainer model, pairing a person with lived experience with mental illness (the peer trainer) with someone who may or may not have lived experience, but has experience facilitating training sessions. Training is anticipated to begin in July, and training sessions will be held in four locations around the state.

In order to improve retention of Peer Support Specialists (PSS) and Family Peer Support Specialists (FPSS) in the workforce, CCHII will be utilizing realistic job previews so that prospective PSS and FPSS have an accurate picture of their role and responsibilities before they take on the job.

Work Plan Two will be submitted in August and is focused on reviewing and further developing certification for PSS and FPSS. CCHII must develop a set of competencies that stakeholders agree all peer support professionals should have. They are reviewing nationally recognized curricula to find well-accepted competencies that already exist. There will be more listening and feedback sessions to seek stakeholder input.

CCHII will develop a new certification process for Family Peer Support, and evaluate the current Peer Support certification process and see whether or not it lines up with the competencies they will be developing. There will also be a process by which people who are currently working in this field can qualify for this new certification.

Work Plan Three is focused on continuing education and training for PSS, FPSS, and those who will be supervising them. This work plan will be submitted in October. CCHII

will have another collaborative process with stakeholders to determine the amount and form of continuing education will be necessary to retain certification.

Discussion:
Advisory committees are being formed and will consist of between twelve and fifteen people ranging from Integrated Health Home (IHH) providers and team-members to people who are currently receiving peer support services and other stakeholders. Vickie asks that people who have interest in serving on one of the groups contact Diane Funk (diane-funk@uiowa.edu). Peer support training and family peer support training will be separate programs, but they will utilize the same co-trainer model where at least one trainer will have lived experience with mental health issues. People who are interested in acting as trainers are encouraged to contact Diane Funk. Training will be directed at a high school education level so that it will be accessible to more people. Training sessions will consist of forty hours of training over six days. There are many factors that contribute to the high turnover of peer support staff. There was discussion about unclear roles and expectations, other professionals in the MHDS community who do not understand the role of peer support, and how there has not always been adequate support for PSS and FPSS.

Mental Health and Disability Services Update presented by Theresa Armstrong
Theresa introduces Rose Kim as the new Quality Improvement Analyst under the CDD contract. She will be developing outcomes and data measures for MHDS. Rose recently met with the Iowa Association of Community Providers (IACP) and with MHDS region CEOs to collaborate on the collection and reporting of outcomes data.

MHDS has a Request for Proposals (RFP) for the Projects for Assistance in Transition from Homelessness (PATH) program. The program is designed to assist people with mental illness who are also experiencing homelessness. The current contract is set to expire this year, and so MHDS is beginning the procurement process. MHDS will need to have contracts in place by July 1, 2015. These programs will be located in areas where the need is greater such as urban centers. Bids are due by May 1st, and a letter of intent is not required to submit an application.

HF 218/HF 600: Requires Medicaid to pay for telehealth services. Medicaid already pays for telehealth services; this bill just codifies that as a requirement.

HF 449: Directs DHS to develop an inpatient psychiatric bed tracking software package. DHS has already been working on the system, but this bill adds a $200,000 appropriation. This is a response to a legislative report from December 2013. This system will make finding an inpatient bed much more efficient.

HF 468: Would give County Board Supervisors the authority to appoint Mental Health Advocates rather than the courts. Those advocates would be employed and supervised by counties. This is in response to recommendations from a judicial workgroup asking for more consistency to the mental health advocacy system. This legislation does not define the responsibilities or caseloads of Mental Health Advocates.

HF 510: Allows counties to contract with a private entity for transportation of individuals who are being committed for mental health or substance abuse reasons. This is already being done in some places as it is not forbidden; this bill provides guidelines on the structure of the contracts.

SF 440: Allows MHDS regions to contract with Mental Health Facilities in neighboring states for admissions as long as the other state has reciprocating laws that will honor commitment orders from Iowa.

SF 386: Establishes a stakeholder workgroup for persons who are sexually aggressive, combative, or who have unmet geropsychiatric needs.

SF 401: Would allow involuntary commitments to be made at the sub-acute level instead of just at the acute level. Currently, sub-acute care is only voluntary. This bill also increases the number of sub-acute beds that can be established in Iowa from fifty to seventy-five.

SF 463: Is an MHDS redesign "clean-up" bill that updates language in the code, for example, places that currently say "county" will be changed to "MHDS region" where applicable.

SF 464: Would renew the Prevention of Disability Council which is set to sunset at the end of the fiscal year. This bill would renew the council and remove the sunset making it permanent. The bill also updates membership requirements to include state departments.

SF 333 and SF 402: Both of these bills relate to the closure of the Mental Health Institutions. SF 333 and SF 402 would require the closing MHIs to accept patients until June 30th. SF 402 would also require a detailed succession plan to be in place before the Clarinda and Mount Pleasant MHIs are allowed to close.

SF 452: Establishes a legislative commission to oversee the Medicaid transformation process.

HSB 177: This bill would direct 70% of Mental Health Block Grant (MHBG) dollars to the MHDS regions instead of being distributed to community mental health centers. 25% would still go to other services and supports in the state.

Discussion: Community Mental Health Centers (CMHC) have expressed concern that dollars going directly to providers would be directed through the regions under this bill, and priorities would change. MHDS regions would need to meet the federal block grant standards just as DHS does. The regions have expressed concern with the formula that determines the distribution of MHBG dollars, and have suggested it be done on a per capita basis. Theresa says she expects to see amendments to this bill, and this is one possible way to distribute MHBG dollars.

HF 543: Marsha Edgington explains that this bill would limit resource centers to a maximum census of 395 people. This bill would also require that resource centers not take any new admissions after July 1, 2015, which will permanently reduce the census of resource centers.

Iowa Medicaid Enterprise Update presented by Liz Matney and Deb Johnson

Currently Medicaid is a large program with approximately 560,000 enrollees and a budget of approximately $4.2 billion. Medicaid in Iowa has seen a growth of 73% since 2003, and is projected to see another 21% growth over the next few years. IME already uses managed care in the form of Iowa Plan for Behavioral Health, a contract with Meridian as a health management organization (HMO), The Iowa Health and Wellness Plan that operates through an HMO, Primary Care Case Management (PCCM) also known as Medipass, Non-Emergency Medical Transportation (NEMT), and the Program for All-inclusive Care for the Elderly (PACE). Liz notes that these programs are very specific in the populations they serve and the service they provide, which creates fragmented care. The challenge IME is attempting to address is the lack of a single unified system of care. These systems do communicate, but often they do not communicate well enough. Many enrollees do not receive overall care coordination.

Liz also pointed out that payment is currently not tied to patient outcomes or client satisfaction. Fee for service pays based on volume, not quality of outcomes. Liz states that the current system does not manage the care for enrollees, and this leads to more expensive services. 28% of Medicaid enrollees are older adults or persons with disabilities, but these populations account for 71% of total Medicaid costs. These individuals may or may not have care coordination services through community-based case managers, integrated health homes or chronic condition health homes. Currently there are smaller managed care systems for the Medicaid population, but no overarching care coordination for all of a person's health needs.

Currently, thirty-nine states and the District of Columbia contract with managed care organizations for Medicaid services. Nationally over half of Medicaid enrollees are on managed care plans. IME is talking to several states who have implemented Managed Care plans. Some states have done so recently, and others have older and more established plans. IME is learning about the hurdles and challenges associated with implementing a managed care plan.

The state will pay the MCOs a per member per month (capitated) rate determined by an actuarial analysis. These payments added together will allow the MCO to manage the care of their members. IME plans to move the vast majority of their members into a managed care system. Medicaid Modernization will create a single system of care that will oversee all of members' health services, and coordinate them so they to provide access and prevent duplication.

“The Iowa High Quality Health Care Initiative” is a term used interchangeably with “Medicaid Modernization” and refers to the same plan. IME is looking to contract with two to four MCOs who can operate and manage care for people statewide. IME intends to have at least two so that members will have a choice, and will not exceed four because if an MCO doesn’t have enough members, they will not be able to spread risk enough to be cost-effective. Governor Branstad estimates saving $51.3 million in the first six months due to increased efficiency. Liz stressed that the program will not save money due to cutting services, but by removing redundant services and by preventing readmissions into hospitals.

IME will be measuring outcomes from MCOs. Performance measures and performance targets will be required from contractors. All MCOs will have an external quality review, and the results will be reported to CMS. IME will also have expectations and performance targets for the MCOs. There is a pay-for-performance aspect in the RFP where IME will withhold a small portion of the capitated payment, and the MCO will only receive that portion if they meet quality standards. In the first year, the standards will mostly be operational standards such as paying claims in a timely manner and member authorizations being processed quickly. Within a year or two, the standards will shift to member outcomes. The outcomes are not expected to be fixed, as IME’s priorities change and they see needs change, performance outcomes may change to reflect that. Liz invites input on performance measures that stakeholders think should be included.

The vast majority of Medicaid members will be included in this initiative. PACE members are not automatically included. PACE members are not included because they are already in an all-inclusive managed care system. Members who are on another insurance plan, but having their premiums paid by IME such as the Health Insurance Premium Payment Program (HIPP) or the Medicare Savings Program, and people with retroactive eligibility will not be included. Retroactive eligibility claims will be paid on a fee for service basis, and then the individual will be assigned prospectively. American Indians and Alaskan Natives can opt in, but are not automatically assigned. Undocumented persons who are eligible for emergency services are not included because they are in the system for a short period of time and managed care would not provide a benefit.

All traditional Medicaid services will be included with the exception of dental services. Liz says this is due to the success of the Dental Wellness Program, which will continue. MFP services will not be included, and will continue to be operated through a grant as they are today.

When members enroll, they will be given the opportunity to select an MCO. If they do not make a selection, they will be tentatively assigned to one, but will have ninety days to choose other one. Members will be able to choose a new MCO annually at the time of re-enrollment, and they will have the ability to change at any time for good cause.

There will be transition periods within which members can keep their current providers. After the transition period, MCOs will be able to manage their network how they see fit.

MCOs will be required to contract with any provider who wants to contract with them. members will be able to keep their current physician for at least six months. CMHCs and long term care (which includes HCBS) has a two year transition period. Premium requirements will not change for members. If a member has a case manager, the MCO must allow the member to keep their case manager for at least six months, however it is expected that all case management functions will be assumed by the MCO within a year. If services are reduced, removed or modified, the member will have appeal rights with the MCO, and if the dispute is not resolved there, they can request a hearing with the state. MCOs must honor existing care authorizations for at least three months during the first year, and after the first year, they must honor existing authorizations for at least thirty days. For the first six months of operation, reimbursement rates will stay the same. After six months, there will be a rate adjustment taking risk factors into account, but rates cannot fall below the current Medicaid rates.

The state was awarded a State Innovation Model (SIM) Grant in December 2014 to help the state continue to redesign the payment system. IME is planning on contracting with Accountable Care Organizations (ACOs) and pursuing shared savings. MCOs will be required to use the Value Index Scores (VIS), a system for measuring outcomes. MCOs will also need to identify the percentage of value-based contracts in place by 2018. These contracts could be shared savings arrangements, pay for performance contracts, bundled payments for episodic care as opposed to fee for service, pay for improvement of quality metrics, etc.

Liz indicated that the Department will continue to read and consider all comments received, even after the close of the formal comment period.

IME had originally planned for an 1115 demonstration waiver from CMS, but after consultation with CMS, a 1915b/1915c combination waiver program may be pursued, and IME will be seeking public comment around June of this year. There have been questions about what happens if CMS does not approve the waivers by January 1, 2016. Liz says if that were to happen, Iowa would not be able to use federal money, but IME is working with CMS every step of the way in the waiver application process. IME has received constant input from CMS over the past few weeks and CMS will see every part of the application in some form before it is formally submitted, so IME is hoping for an expedited review process.

Stakeholders are encouraged to ask questions and provide feedback. Information on future public meetings, the questions and comments email address and the link to the RFP itself can be found at
https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization

Discussion:
Dental services will continue to be covered by IME rather than the managed care organizations.

The enrollment algorithm will not take medical history into account, rather it will focus on the county that the enrollee lives in and whether or not they had been enrolled in a managed care plan before. There will be a readiness review before the MCO is allowed to become active. If the MCO cannot satisfy access and readiness criteria, they will not be allowed to start. IME has not yet determined exactly what will happen instead. There are currently seventeen MCOs who have submitted letters of intent for the Medicaid Modernization grant. A letter of intent is not required to submit a bid. Members who receive retroactive coverage will have their claims paid on a fee-for-service (FFS) basis.

A break was taken for lunch at 12:45 pm.

The meeting resumed at 1:45 pm.

Regional Core Services presented by Suzanne Watson and Deb Schildroth
Southwest Iowa MHDS is working on a standardized crisis assessment tool. Use of the tool is not required, however Suzanne says she believes it will be very beneficial. Southwest is also expanding mobile crisis services from Pottawattamie County to the rest of the region. Suzanne says there are plans to put a three to five bed residential crisis facility in the southern part of the region. There is now a Mental Health Court in Pottawattamie County, and five court dates have been set. There was a judge who showed interest in the early stages of planning and volunteered for the position.

Central Iowa Community Services has done a service gap analysis to find needs within the region. Central Iowa now has a supported employment program in all ten counties. The region is currently working on setting up tele-psychiatry services in hospitals. Deb says that transportation services have increased to allow people with disabilities to be more mobile and capable in the community. The region has provided funding to the National Alliance on Mental Illness (NAMI) Central Iowa to hire a fulltime director on the condition that the director reaches out to the whole region as some counties do not have a NAMI chapter.

Discussion:
The regions are using peer support services in certain settings, and will look to expand those services when there are more PSS available. Currently the Mental Health Court in Pottawattamie County has a fulltime case manager, a mental health practitioner, the assistant county attorney, a public defender, probation staff, and other staff to support the court. Court staff meets every Wednesday and court dates are held biweekly. Southwest Iowa MHDS is planning to expand the Mental Health Court to the rest of the region.

Neil asked if the regional system was starting to come together. Deb and Suzanne say that regional CEOs meet every month or so to collaborate and learn from each other. The initial organizational headaches such as staffing are being dealt with, and for the most part, regions are moving ahead and working on long term funding strategies.

Continuation of Department of Human Services Discussion

Deb Schildroth noted that mental health and substance abuse have been under managed care for approximately nineteen years, and asked if there are any more savings to be gained in those areas.

Teresa answered that she had heard testimony from two experts who said that Iowa might not save as much as was estimated based on current reimbursement rates. Teresa noted that there are no outcomes and performance measures yet. Deb Schildroth says that there is a performance manual being drafted and that will be available soon. Patrick asked if the manual will be available to the public or only to the bidders. Theresa answers that it will be available on the bid opportunities website.

Teresa Bomhoff notes that the contractors will need to get DHS approval before being allowed to implement several policies. She expressed concern over possible conflicts of interest and asked if there should be independent oversight. Theresa says that IME (division of DHS) is expected to have oversight over the RFP.

Bob Bacon asks who has the responsibility for building the capacity of the system. Teresa commented that parts of the RFP mention that the MCO will be responsible for training workforce, and that NAMI has suggested that the legislature have oversight of workforce development.

Teresa expressed concern over credentialing and how providers might need to credential with up to four MCOs. She suggested that credentialing be handled centrally at IME. Patrick says that credentialing is a large undertaking and that he employs a part time employee just to handle credentialing.

Planning for April and May Meetings
Patrick asks for people to volunteer to serve on a nominations committee.
Deb Schildroth, Neil Broderick, and Marsha Edgington volunteer to serve on the nominations committee. The committee will nominate a slate of officers to serve for the next year on the Commission.

The next meeting is scheduled for April 16 at the Hoover Building Level A Conference Room 7.

Requests were made to continue discussion on Medicaid Modernization and The Peer Support and Family Peer Support projects.

Bob Bacon asked to hear about funding challenges for the MHDS regions.

Public Comments
Patrick thanked Connie Fanselow for her years of service to the Commission.

The meeting was adjourned at 3:00pm.

Minutes respectfully submitted by Peter Schumacher.